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AUTHOR Guerney, Bernard
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ABSTRACT

Looking at prevention from the perspective of the psychoeducational skill-training model sharply diminishes the apparent differences between psychologically based treatment and prevention since both are seen strictly as educational processes. The sole important difference is timing, with treatment being delayed and relatively inefficient and costly education. The psychoeducational model's emphasis on motivation and specified performance objectives also suggests preventionists would profit from: (a) even more clearly delineating and emphasizing the positive, strength providing components of a prevention program; (b) giving greater emphasis to those aspects of a program which meet current felt-needs; and (c) reducing emphasis on discrimination between those who are supposedly normal, and those who are supposedly abnormal or suffering from problems. Such changes in emphases might aid in designing, financing, marketing, implementing, and evaluating prevention programs. The psychoeducational skill-training and prevention movements can be viewed as part of the same fabric. (Author)

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The Great Potential of An Educational Skill-Training Model In Problem Prevention[1]

Bernard Guerney, Jr.[2]

The Pennsylvania State University

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Abstract

Looking at prevention from the perspective of the psychoeducational skill-trianing model sharply diminishes the apparent differences between psychologically based treatment and prevention since both are seen strictly as educational processes. The sole important difference is timing, with treatment being delayed and relatively inefficient and costly education. The psychoeducational model's emphasis on motivation and specified performance objectives also suggests preventionists would profit from: a) even more clearly delineating and emphasizing the positive, strength providing components of a prevention program; b) giving greater emphasis to those aspects of a program which meet current felt-needs and; c) reducing emphasis on discrimination between those who are supposedly normal, and those who are supposedly abnormal or suffering from problems. Such changes in emphases might aid in: 1) designing, 2) financing, 3) marketing, 4) implementing, and 5) evaluating prevention programs. The psychoeducational skill-training and prevention movements can be viewed as part of the same fabric. When so viewed they seem on the verge of having a beneficial impact that is truly revolutionary.

The Great Potential of An Educational Skill-Training Model[1] In Problem Prevention

When Kessler and Albee were asked to review the literature on primary, secondary, and tertiary prevention for the Annual Review of 1975, they found the task outside the realm of possibility. Even when they limited themselves to primary prevention, they found the job to be so "...amorphous as to defy adequate coverage." Emory Cowen, like Kessler and Albee, a major advocate of the prevention movement describes psychologists' understanding of primary prevention with words like "confusion," "diffusion," and "mishmash." Perhaps it will only add to the confusion, but my major purpose in this paper is to take a look at prevention from the perspective provided by the educational skill-training model of "psychotherapy" and share the observations with you in a very tentative and exploratory spirit.

First, let me say that I am limiting these observations to one half of the prevention field as it has been dichotomized by Cowen (1977). I will be considering only the half that deals with competency training and not the half that deals with social engineering--the reform of our institutions and social structures at local and national levels. Another disclaimer that I must make is that this paper will concern itself only with voluntary treatment and only with psychogenic causes and effects.

I will now briefly explain the concept I have of the educational skill-training model (Authier, Gustafson, Guerney, Kasdorf, 1975; Guerney, Guerney, Stollak, 1972; Guerney, Stollak, Guerney, 1970; Guerney, Stollak, Guerney, 1971). To me this model does not end, but rather begins with the replacement of medical terms and analogs by terms derived from the social sciences and learning theory The model includes many other concepts and procedures besides those involved in treatment per se. In the educational skill-training model, the concept of abnormality or illness is replaced by the concept of dissatisfaction or ambition; diagnosis by value prioritization; prescription by the design of instructional programs; therapy by skill-training; and cure by greater personal satisfaction or goal achievement. In addition, the educational model attempts to replace the attitudes and implicit interpersonal contracts characterizing an enlightened healer with the attitudes and implicit interpersonal contracts characterizing an enlightened teacher.

The educational model of which I speak also accepts the burden of a mass clientele, a burden which includes the demand for planning, precision, replicability, and systematization. The educational skill-trianing model would replace institutional set-ups resembling those in which healers typically practice--hospitals, clinics and private offices--with a continuing education set-up wherein classes could be conducted in almost any setting and which, when programs are organized by one institution, would constitute a School for Living.

Such a school would coordinate many dozens of offerings that were broad and deep enough to allow clients to shape their own values and

personalities in much the same way as a good school devoted to cognitive development allows pupils to shape their own intellectual growth. Transcripts and certificates of accomplishments added to the strong drive most people already have for personality development would motivate people to acquire competence in handling their emotions and interpersonal relationships in much the same manner as high school diplomas and certificates of graduation from business school motivate people to acquire intellectual competence today.

It is important to note that none of the major goals of traditional psychotherapists are abandoned when one switches from a medical to an educational model of delivering psychosocial services. The only thing which changes are the methods by which the objectives are pursued. It is also important to note that in my view, the new psychosocial skill-training programs will not be successful unless their design and execution makes use of the central principles and practices developed over the last several decades by relationship oriented therapists and by behavior modifiers. The psychoeducators will be a new breed, the offspring of therapists and behavior modifiers mated to teachers of traditional subject matter. From the behavior modifiers and therapists will come expertise in the application of principles of learning and attitude change and expertise in dealing with the self-concepts and defense mechanisms of learners. From the teachers of traditional subject matter will come expertise in planning, administration, organization, the design of performance objectives, the use of audio-visual materials, the use of instructional aids, etc.

That completes my cursory outline of the kinds of changes which might ensue from the completion of the revolutionary change toward the full scale replacement of the medical model by an educational skill-training model. What new lights and shadows does the educational skill-training model cast on the field of prevention?

For one thing, it may help to reduce some of the great confusion that exists in the minds of most of us when we attempt to define prevention. Prevention and treatment in the past have seemed to involve two different kinds of processes. I believe this conceptualization came about like many of our other troubles from thinking in terms of medical analogues instead of educational analogues. Not always, but very frequently in medicine, the process involved in prevention is very different from the process involved in treatment. Persuading people to use breakaway ski boots is very different from setting a broken ankle. Persuading people to keep food refrigerated is a very different process than pumping out their stomachs. Thus, in medicine the process frequently used in prevention stands in contrast to the notion of treatment or therapy.

Once one adopts the educational model, the concepts of prevention and of treatment are no longer seen as essentially different procedures. In education, remedial instruction is the analog of treatment. Remedial instruction is still instruction, it is not something else. In mental "health," as viewed from the vantage point of the educational model, treatment is instruction; that is, it is skill-training or competency-training. It is not something else. Hence, from this perspective, the only essential difference between prevention and remediation in the realm of "mental health" is not a difference either of kind or of process, but rather one of timing.

In instruction, remedial education is simply a program of education which is necessitated by some earlier failure or gap in the educational system. Someone has to undergo a program of remedial instruction either because the design of the original program of instruction in the schools did not allow for some kind of divergence from the norm by the child--for example, a child being too low in intelligence or being of mixed dominance--or because the program was imcompetently administered by one or more teachers.

Remedial instruction, therefore, is simply instruction which comes later than it should have. The result of the delay is that the recipient has suffered more inconvenience, pain or harm than should have been the case. Also the cost of such instruction, since it must be more individualized, and often must undo secondary damages resulting from the delay, usually is much greater than similar instruction could have been in a more properly designed or administered system. Thus, from the perspective of an educational model, remedial instruction actually is delayed, inefficient and costly instruction.

Translating this back to medical terminology: psychological treatment is nothing more nor less than a delayed, inefficient and expensive program of prevention. That relationship has been masked by the medical model because in the physiogenic realm, treatment and prevention often really necessitate very different procedures. It is only when one and the same process--skill or competency training--is seen as the most efficient means of treatment, as well as a means of prevention, that this relationship becomes clear.

A second feature of the mental health landscape which appears in a different light to me when I look at it from the perspective of the

educational model is the issue of accountability. The problem can be summarized by an experience recently reported to me by a young mental health worker in a Consultation and Education department of a mental health center who told me that she was upset and demoralized because she didn't know how to answer a psychiatrist who challenged her to defend her budget by telling him just how her primary prevention programs were going to prevent schizophrenia. I told her that she should have told the psychiatrist she was just now on the verge of successfully completing her project on preventing the common cold and would get back to him in a few weeks on her schizophrenia-prevention project. Both the question and my answer are pertinent. One of the first things that happens to you shortly after you exchange your medical model spectacles for your educational model spectacles is that questions like the psychiatrists's appear so funny as to merit only an attempt to be funny in return. Why?

When you take the stance of an educator rather than of a healer, you immediately begin to think in terms of your training objectives. As an evaluator within the educational model, you think in terms of performance criteria. Unless and until someone can describe the skill a person needs to avoid developing a specific problem--including a problem such as schizophrenia--and these specific skills are incorporated into a program, it makes very little sense to expect to either overcome, or prevent that problem.

A third observation is closely related to the preceeding ones. Decades of experience and study in cognitive education tell us that fulfilling an immediately felt need-to-know--which pretty much amounts to motivation to learn--is one of the key ingredients in designing and

delivering successful teaching programs. I believe advocates of any type of program which could currently be described as a preventative program, are doing themselves and their program an injustice if they concentrate exclusively on what the program may help to prevent. I believe they also should focus on what kinds of satisfaction and goal attainments the program will provide, especially those it will provide in the present. Making sure that fulfilling present needs is a recognized feature of a preventative program may facilitate the program's design, its sponsorship, its effectiveness and the breadth and speed of its acceptance by the public. Acceptance by the public is a factor in the next type of light cast on the field of prevention by the educational model. This light is a rosy one.

The educational model teaches us to view things from a positive rather than a negative perspective. The advantage of such a perspective is analogous to the advantage that the skilled behavior modifier achieves when he learns how much more effectively he can solve problems when he learns that generally it is far better not to try to punish people for doing the wrong thing--catching them being bad--for example, a child making noise in the classroom; but instead, to identify the reciprocal, good behavior and reinforce it--catching people being good--for example, praising the child when he does remain quiet. The medical model has encouraged us to look at the negative and try to eliminate it directly. It doesn't encourage us to try to give people something positive. Even in traditional, clinical practice we could as easily tell people we will help them to acquire courage as we could tell them we will reduce fear, or we could help them to achieve greater sexual enjoyment rather than say that we'll cure their frigidity. But the medical model has discouraged us from thinking in this way.

From the point of view of reason or logic, educators could have taken the same approach. But they did not, and they do not. They take a positive approach. They don't say they will cure our children of their illiteracy, they say they will help them to learn to read. They don't talk of drowning prevention but of swimming instruction. They talk of driving instruction not accident prevention. The emphasis on the immediate and on the positive has, I believe, great advantages when it comes to being able to convince the public to accept and support programs. It also, I believe, has a great advantage in terms of establishing the correct kinds of criteria by which your program should be evaluated, not only now, but many years later. It should help to prevent people from asking the overly broad kinds of questions I cited earlier in the anecdote and prevent them from holding educational oriented programs accountable for things for which such programs should not be held accountable.

In our own programs of Relationship Enhancement (1977) persons of a wide range of ages, are taught how to relate to others honestly and compassionately and to better meet the emotional needs of others and how to maximize the probability that others will respond to them in like manner. In these programs we emphasize present gains while also explaining to clients the potential the program might afford for avoiding future problems. Of equal importance, we deliberately offer exactly the same program (which has flexible time boundaries) to people who want to solve serious current relationship problems, to people who want to avoid such problems in the future, and to people who want to further enrich an already splendid relationship. There is no discrimination on the basis of how serious a person's problems are or whether he has a problem at all. The only requirement is a desire to improve.

I believe that in the future a very wide array of programs that are similarly non-disciminatory with respect to so-called pathology will become available to the public. Such programs will be helpful to people from before their birth--via preparation of their parents during the pre-natal months, to the time they may want to prepare for death. Such programs will be available in places of work, worship, traditional schooling and in various kinds of institutions specifically set up to provide such programs. The first steps have already successfully been taken in all these respects. I think that as soon as the general public begins to realize that they no longer need to regard themselves as sick of deficient in any way to avail themselves of psychological help, as soon as they realize that they may instead perceive themselves as being enriched by acquiring new skills, as shaping their own personalities to their own desires, then the demand for programs which serve the purpose of preventing psychoemotional and social programs of many kinds will expand explosively.

I believe affective education (Long, 1970) psychoeducation, enrichment, enhancement and training-as-treatment are essentially very similar waves in the rising tide that could be called by any one of those names, but which I prefer to call psychosocial skill-training. I believe that psychosocial skill-training eventually will have the same revoluationary beneficial impact on the mental "health" and welfare of the public that I believe learning to read has had on the development of the public's intellectual "health" and welfare. The advent of psychosocial behavioral literacy through psychosocial skill-training also will be the Golden Age of prevention. I believe we are now in the dawning of that age.

Footnotes

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